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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification and complaint survey conducted at your facility on 1/23/09 through 1/30/09. The census at the time of the survey was 181. The sample size was 30 including 3 closed records. There were 5 complaints investigated during the survey: CPT # 20461 Substantiated without deficiencies. CPT # 20626 Substantiated (Tag F323). CPT # 20630 Substantiated (Tag F323). CPT # 20698 Substantiated without deficiencies. CPT # 20730 Substantiated (Tag F323). CPT # 20785 Substantiated (Tag F323). The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000		
F 154 SS=D	483.10(b)(3), 483.10(d)(2) NOTICE OF RIGHTS AND SERVICES The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.	F 154		3/9/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure 1) information and the right to refuse treatment was presented to the responsible party; and 2) consents from the responsible party were obtained prior to treatment for 4 of 30 residents (#5, #8, #19, #25).

Findings include:

Resident #5

Resident #5 was a 52 year-old male with diagnoses including severe mental retardation, hypertension, atrial fibrillation, contractures and open wounds.

Resident #5's record had a physician's order, dated 6/27/08, for Valium 1 milligram (mg) via feeding tube every 12 hours for muscle spasm. The record contained a physician's order, dated 6/27/08, for Valium 2 mg via feeding tube every 8 hours for anxiety/agitation or muscle spasm.

Resident #5's record contained an "Informed Consent for Treatment with Psychotropic Medications." The form listed the two different dosages of Valium. The form was signed by the resident's physician and dated 10/20/08.

The signature/date line for the responsible party to give consent for the medication was blank. There was no documentation indicating the responsible party had been contacted regarding the administration of Valium. Resident #5 had been receiving the medication since June 2008.

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Resident #8

Resident # 8 was a 60 year old male who was a long time resident of the facility readmitted on 12/4/08. The resident's diagnoses included cerebral vascular accident, hypertension, chronic dementia and depression. The resident had a Percutaneous Endoscopic Gastrostomy tube (PEG) and received tube feedings daily. He had oxygen in place via nasal cannula and was suctioned as necessary. The resident was alert but not verbally responsive and was unable to move his extremities.

Documentation on the Medication Administration Record (MAR) for October and November 2008 showed that Resident #8 was receiving Lexapro 10 mg (milligrams) po (by mouth) daily.

The consent form was in the chart but was only signed by the doctor. The consent was not signed by any family member, nor POA (Power of Attorney).

Physician orders dated 12/4/08 indicated: Lexapro 10 mg 1 tab every day via PEG tube for depression

The MAR revealed Resident #8 received Lexapro daily from 12/5/08 through 12/14/08.

The "Informed Consent for Treatment with Psychoactive Medications" dated 12/15/08 at 2010 (8:10 PM), indicated "Notified POA. Refuse to have this med (medication) for his son."

Lexapro discontinued by physician on 12/14/08.

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(Note: The facility's notes have inconsistent dates for this and the above paragraph.)

On 1/29/09 in the morning, the DON confirmed there was not a signed consent for Lexapro for this resident.

Resident #19

Resident #19 was a 77 year old female admitted on 5/9/08, with diagnoses to include congestive heart failure, hypertension, end stage renal disease, anemia, chronic back pain and chronic airway obstruction. The resident only spoke Vietnamese.

The medical record for Resident #19, had a physician's order for, "Ambien 10 milligrams by mouth hour of sleep when necessary." The resident's medical record contained an "Informed Consent for Treatment with Psychotropic Medications" with the resident's name and the name of the medication. The form had no documentation that the resident or a responsible party signed the consent.

Resident #25

Resident #25 was a 63 year old admitted on 9/25/08, with diagnoses including end stage renal disease, schizophrenia, history of Parkinson's disease, and dementia.

Resident #25's medical record dated 09/26/08, had a physician's order for, "Ativan 0.5 mg (milligrams) 1 tab (tablet) po (by mouth) Q (every) 4 hours prn (as needed)" and "Restoril 15 mg 1 tab po Q HS (hour of sleep) prn."

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F 154	Continued From page 4 Resident #25's medical record contained an "Informed Consent for Treatment with Psychotropic Medications" form dated 9/26/08, with the resident's name and the medications Ativan and Restoril listed. The form had an illegible signature on the "Licensed Nurse" line and "verbal consent" written next to the licensed nurse signature. The form had no documentation the resident or a responsible party signed the consent.	F 154		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the	F 279		3/9/09

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interventions for residents described in the care plans were provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 5 of 30 residents (#1, #6, #7, #18, #19).

Findings include:

Issue One:

Resident #1

Resident #1 was an 89 year old, re-admitted on 12/13/08, with diagnoses including status post fracture of left hip, hypertension, osteoporosis, and dementia.

The resident's care plan included a problem of "Cognitive loss (#2) Delirium or periodic disordered thinking or awareness--not of recent onset." The "cognitive loss" problem was dated "1/26/09 to 4/09" and included the following intervention: "Provide clock, calendar, and family photos in resident's room."

On 1/27/08 in the late afternoon, and on 1/28/09, 1/29/09 and 1/30/09 in the late morning and mid-afternoon, no clock was present in the resident's room on the walls, bedside table, or bedside stand.

Resident #6

Resident #6 was an 86 year old, re-admitted on 5/8/07, with diagnoses including diabetes, hypertension, coronary artery disease, and dementia.

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The resident's care plan included the problems of "Cognitive loss (#2) Delirium or periodic disordered thinking or awareness--not of recent onset" and "Cognitive loss (#2) Memory problem." Both "cognitive loss" problems were dated "1/12/09 to 04/09" and included the following intervention: "Provide clock, calendar, and family photos in resident's room."

On 1/27/09 in the afternoon and 1/28/09, 1/29/09, and 1/30/09 in the late morning and mid-afternoon, there was no clock in the resident's room on the walls, bedside table, or bedside stand.

Resident #7

Resident #7 was an 85 year old, re-admitted on 7/27/07, with diagnoses including type II diabetes, hypertension, and dementia.

The resident's care plan included a problem of "Cognitive loss (#2) Memory problem." The "cognitive loss" problem was dated "12/8/08 to 03/09" and included the following intervention: "Provide clock, calendar, and family photos in resident's room."

On 1/27/09 in the late afternoon and 1/28/09, 1/29/09, and 1/30/09 in the late morning and mid-afternoon, there was no clock present in the resident's room on the walls, bedside table, or bedside stand.

Resident #18

Resident #18 was a 77 year old, admitted on

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11/11/05, with diagnoses including Parkinson's disease, hypertension, status post cerebrovascular accident, depression, and dementia.

The resident's care plan included problems of "Cognitive loss (#2) Memory problem, and "Cognitive loss (#2) Delirium or periodic disordered thinking or awareness--not of recent onset." The cognitive loss problems were dated 1/13/09 to 04/09 and included the following intervention: "Provide clock, calendar, and family photos in resident's room."

On 1/27/08 in the late afternoon, and on 1/28/09, 1/29/09 and 1/30/09 in the late morning and mid-afternoon, no clock was present in the resident's room on the walls, bedside table, or bedside stand.

Interview

On 1/27/09 in the late afternoon, the Unit Manager explained that clocks in the resident rooms would not be used by residents of the 300 hall. On 1/30/09 at 1:50 PM, the Administrator and Director of Nursing related that clocks were taken and missing from resident rooms.

Note:

The care plans for "Cognitive loss (#2) Memory problem" had the following goal statements:
- "Resident will demonstrate orientation to person, time, place" and
- "Resident will demonstrate ability to remember mealtimes."

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The care plans for "Cognitive loss (#2) Delirium or periodic disordered thinking or awareness--not of recent onset" had the following goal statement:
- "Resident will demonstrate orientation to person, time, place."

The absence of clocks in 300 Hall resident rooms did not facilitate meeting the stated goal(s) of "orientation to time" and remembering "mealtimes."

Issue Two

Resident #19

Resident #19 was a 77 year old female admitted on 5/9/08, with diagnoses to include congestive heart failure, hypertension, end stage renal disease, anemia, chronic back pain and chronic airway obstruction.

During the initial tour on 1/27/09 in the morning, the Nurse Manager of the 100 hall indicated Resident #19 spoke Vietnamese. The nurse indicated her family and one of the physicians communicated with her in Vietnamese. She indicated the physician came once a week and her family visited frequently.

Resident #19 was interviewed on 1/29/09 in the morning. The resident was unable to complete the interview due to lack of understanding the questions. There was no one available to speak to the resident in her language.

Two Interdisciplinary Team forms dated 10/23/08 and 1/29/09 indicated, the resident did not attend or participate in her interdisciplinary care

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F 279	Continued From page 9 conferences because she only spoke Vietnamese. On 1/30/09 in the afternoon, the Administrator indicated the staff used a communication sheet with pictures and an interpreter phone line to converse with non-English speaking residents. There was no evidence of a communication sheet in the resident's room. The plan of care for Resident #19 contained no documentation of how the staff communicated with the resident when her family or the physician were not present.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document and record review, the facility failed to provide the necessary care and services in accordance with the comprehensive assessment and plan of care for 2 of 30 residents (#1, #11). Findings include: Resident #1 Resident #1 was an 89 year old re-admitted on	F 309		3/9/09

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12/13/08, with diagnoses including fractured left hip status post surgical repair, hypertension, osteoporosis, and dementia. Resident #1 was readmitted from the hospital with a Foley catheter in place per physician order of 12/17/08. Resident #1 was admitted to hospice care on 1/14/09.

On 12/21/08, a urinalysis and culture were collected from Resident #1 per Doctor's order. The results included the following abnormal findings:

- "cloudy"
- "blood 2+"
- "nitrite POSITIVE"
- "WBC (white blood cells) > 50"
- "RBC (red blood cells) 21 - 50"
- "bacteria many"
- ">100,000 colonies/ML (milliliter) proteus mirabilis."

On 12/24/08, Resident #1's urinalysis and culture results were reviewed by RN. On 12/27/08, a physician's order for Resident #1 was received for the following medication, "Cipro 250 mg (milligrams) po (by mouth) BID (twice a day) x (times) 5 days T.O. (telephone order)..."

On 12/28/08, a physician's order from Resident #1's MD/Physician was received which stated the following:

-"D/C (discontinue) Cipro"
- "Start c (with) Levaquin 250 mg Q (every) D (day) x 10 day and repeat UA (urinalysis), C+S (culture and sensitivity) after 2 wks (weeks) T.O..."

On 1/12/09, Resident #1 urinalysis and culture

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was collected and results reported on 1/14/09. The urinalysis and culture included the following abnormal findings:

- "cloudy"
- "blood 3+"
- "nitrite positive"
- "WBC > 50"
- "RBC 4 - 10"
- "bacteria Mod (moderate)"
- "> 100,000 colonies/ML MIXED FLORA NO PREDOMINANT ORGANISM."

On 1/17/09, a hand written notation on the 01/12/09 urinalysis and culture results indicated Resident #1's physician was notified of the results. "No new orders" for antibiotic therapy were received from the MD/Physician.

On 1/18/09, the original Doctor documented on a "CERTIFICATION and RECERTIFICATION" form that continued ECF (extended care facility) in-patient care is necessary for the following reason(s). Continues to require skilled rehab services PT/OT/ST (physical therapy, occupational therapy, speech therapy) + (and) nursing services, UTI c ABT Tx (urinary tract infection with antibiotic treatment)."

On 1/26/09, a physician's order for Resident #1 documented the following: "Keep Foley catheter intact until residents next f/u (follow up) visit c (with) orthopedic surgeon (2/3/09) when WBAT (weight bearing as tolerated) will be determined." T/O (telephone order) by Doctor.

On 1/30/09 in the midmorning, the Unit Manager revealed the Foley catheter was in place per the physician's order and the urine specimen was

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obtained using the collection port on the Foley catheter. The Unit Manager explained additional antibiotic therapy was not continued for Resident #1 due to her status as a hospice patient.

On 1/30/09 at 1:50 PM, Resident #1's urinalysis and culture reports dated 12/21/08 and 01/12/09, were reviewed with the Director of Nursing (DON). The DON related a need to "look into this."

On 1/30/09 at 2:50 PM, the Infection Control coordinator reported the hospice had been called regarding Resident #1's abnormal repeat urinalysis and culture and no additional antibiotic therapy was ordered per "hospice practice."

Resident #11

Resident #11 was a 69 year old male admitted on 2/5/07 with diagnoses to include, seizure disorder, altered mental status, dementia, diabetes mellitus type II, right sided hemiplegia, Parkinson disease, hypertension and aspiration risk.

During the initial tour on 1/27/09 at 9:00 AM, the resident was observed lying in bed with bilateral side rails up. The bed was not equipped with pads on the side rails.

The resident's plan of care dated 1/5/08, indicated the resident had a seizure disorder and was on seizure precautions. The seizure precaution protocol included padded side rails when in bed.

The resident was transferred to the hospital on 1/4/09, with an admission diagnosis of "...altered mental status, transient ischemic attack versus

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F 309	Continued From page 13 seizure event." The resident's medication orders on re-admission to the facility on 1/5/09 included, "Keppra 500 milligrams (mg.) by mouth (PO) at bedtime (BT) and Depakote ER 1500 mg. PO at BT. The facility's "Seizure Precaution Policy" dated 08/05, indicated residents on seizure precautions were to have the bed equipped with pads if they had side rails in use. On all days of the survey, Resident #11 was observed in bed at 8:00 AM, 11:00 AM and on 1/27/09, 1/29/09 and 1/30/09 at 2:00 PM. The resident's bed was not equipped with pads. On 1/29/09 at 2:00 PM, there were two blue pads propped up against the wall near Resident #11's bed. The MDS (Minimum Data Set) Coordinator indicated they should be on the resident's bed and she would take care of it.	F 309		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to justify the need for an	F 315		3/9/09

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F 315	Continued From page 14 indwelling catheter for 2 of 30 residents (#12, #14). Findings include: Resident #12 Resident #12 was a 51 year old admitted on 12/20/08, with diagnoses including respiratory failure, renal disorder, anemia, septicemia, obesity and ventilator (vent) dependent. Resident #12's Physician's Telephone Orders form dated 12/23/08, documented: -"...Clamp and unclamp Foley catheter q (every) 2 hours x 48 hours then DC (discontinue)..." -"...If bladder distention or urinary retention noted post DC of foley catheter may reinsert foley catheter..." Resident #12's undated Treatment Record form documented the resident refused to discontinue the Foley catheter. Resident #12's Indwelling Urinary Catheter Justification Assessment Form dated 12/23/08, documented there was no justification for an indwelling catheter. Resident #12's Indwelling Urinary Catheter Justification Assessment Form dated 1/17/09, documented there was a need for an indwelling catheter due to severe impairment of "VDRF" (Vent Dependent Respiratory Failure). On 1/28/09 at 2:45 PM, Resident #12 was lying in bed and had full range of motion to his upper extremities. The resident was alert and oriented	F 315		

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to person, place and time and was able to follow commands and verbalize his needs. The resident was able to reach and use his call light with no difficulty.

On 1/28/09 at 2:45 PM, Resident #12 indicated he had no problems urinating before receiving the indwelling catheter. The resident indicated the staff discussed with him removal of the catheter last December 2008. The resident indicated if the catheter was removed he needed assistance placing the urinal under his abdomen and the nursing assistants were very busy. The resident indicated it was decided to leave the catheter in. Resident #12 stated:

-"... the staff could not guarantee me that somebody would come to give me the urinal every hour..."

On 1/30/09 at 12:45 PM, Employee #20 indicated a meeting was held with Resident #12 in December 2008, to discuss discontinuing his catheter. Employee #20 indicated no alternative plan was given to the resident (such as being assessed for the use for a condom catheter).

Resident #14

Resident #14 was a 27 year old admitted on 12/14/07, and readmitted on 8/20/08, with diagnoses including pneumonia, ventilator dependent, deep vein thrombosis, myocardial infarction, and gastrostomy.

Resident #14's Indwelling Urinary Catheter Justification Assessment Form, dated 8/21/08, documented the resident was admitted with an

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indwelling urinary catheter and the catheter was justified due to a Stage III or Stage IV decubitus ulcer. The form documented the catheter was discontinued on 12/4/08.

Resident #14's Physician's Telephone Orders form dated 12/2/08 documented:

-"...Clamp and unclamp Foley catheter q (every) 2 hours x 48 hours DC (discontinue) secondary wound healed on sacrum..."
-"...May reinsert Foley Catheter if bladder distention or no output post DC of Foley..."

Resident #14's December 2008 Treatment Record form documented the resident's Foley catheter was discontinued on 12/4/08.

Resident #14's Nursing Notes from 12/5/08 to 12/8/08 documented the resident was voiding well, with no difficulty, and the abdomen was soft.

Resident #14's Weekly Intake and Output Evaluation form documented the resident's output for a 24 hour total from 12/4/08 to 12/9/08 was X5, X8, X7, X8, X8, and X8. On 1/30/09 in the afternoon, the Assistant Director of Nursing (ADON) indicated the documentation meant the resident was incontinent of urine and how many times the resident had a wet diaper.

Resident #14's Nurse's Notes, dated 12/9/08 documented:

-"...Abdomen soft with +BS (positive bowel sounds), on incontinence care, kept dry, for reinsertion of Foley catheter Fr. (french) 16 x 30 cc (cubic centimeters)..."

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Resident #14's Indwelling Urinary Catheter Justification Assessment Form, dated 12/13/08, documented there was justification for an indwelling catheter due to failed past attempts to discontinue the catheter. Documented on the bottom of the form:

-"...Foley Catheter was DC on 12/4/08. Noted bladder distention 12/12/08 and foley was reinserted..."

There were discrepancies between the Justification Assessment form and the Nurses Note's.
Resident #14's Nurse's Notes documented the indwelling catheter was reinserted on 12/9/08, not on 12/12/08 as documented on the Urinary Catheter Justification Assessment Form. The nurse's notes dated 12/10/08 documented:

-"...F/C (Foley Catheter) in place draining adequate urine..."

Resident #14's Nurse's Notes dated 12/12/08 documented:

-"...F/C doing well..."

Discrepancies with Resident #14's Certified Nurse Assistant (CNA) Flow Sheet for December 2008, documented on the day, evening and night shift, the resident had a Foley catheter from 12/4/08 to 12/9/08. The Nurse's Notes and the Weekly Intake and Output Evaluation indicated the resident was incontinent of urine during the same dates.

There was no documented evidence Resident #14 did not have urine output or the bladder was

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F 315	Continued From page 18 distended to justify reinserting the indwelling Foley catheter. Resident #14's Physician's Telephone Orders form dated 12/12/08, documented to reinsert the Foley catheter but there was no justification why a catheter was needed. On 1/30/09, in the afternoon, the Director of Nursing (DON) indicated Resident #14's indwelling Foley Catheter was reinserted due to a reopened wound to the sacral area. Resident #14's Skin Progress Report did document a Stage II wound that started on 12/7/08. The wound was healed on 1/2/09 and the indwelling catheter was not discontinued. Note: The wound was not a Stage III or IV ulcer to justify the need for a catheter.	F 315		
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident who was fed and administered medications through a gastrostomy tube received appropriate treatment and services to prevent complications for 1 of 30 residents (#23).	F 322		3/9/09

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Findings include:

Resident #23

Resident #23 was admitted on 2/15/08, with diagnoses including respiratory failure, respirator dependent, cardiac dysrhythmia and anemia.

Resident #23's physician's orders included gastrostomy (G)-tube feedings with Replete at a rate of 55 cc (cubic centimeters) per hour over 12 hours every day.

On 1/28/09 at 7:10 AM, Employee #16 was preparing to administer medications through Resident #23's G-tube. Employee #16 stopped the feeding pump and used a syringe to inject 10 cc of air into the tube while listening to the stomach with a stethoscope to check for placement. Employee #16 failed to pull back on the plunger of the syringe to check for residual stomach contents prior to administering numerous medications and water flushes through the resident's G-tube. Resident #23 complained of a feeling of fullness in her stomach during the medication administration.

On 1/30/09 at 7:10 AM, Employee #16 indicated prior to medication administration through a G-tube, placement was checked by injecting 10 cc of air with a syringe and listening over the stomach with a stethoscope for a bubbling sound. Employee #16 indicated gastric residual was checked once a shift by using a syringe to withdraw stomach contents.

On 1/30/09 at 1:35 PM, Employee #14 explained the facility's policy for medication administration

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F 322	Continued From page 20 via GT/NGT (G-tube/nasogastric tube) indicated the nurse was to check the G-tube placement by injecting 10 cc of air into the G-tube and listening over the stomach for the sound of air. The nurse should then pull back on the plunger of the syringe to check for residual stomach contents. If the residual stomach contents were greater than 100 cc, the medication administration should be held and the physician notified. A physician's order for Resident #23, dated 1/1/09, indicated the resident was to receive Replete at 55 cc per hour over 12 hours. The order included checking the gastrostomy tube for residual, placement and patency every shift and when necessary. If the stomach residual was greater than 150 cc, the feeding was to be stopped and the physician notified. The facility's "Administration of Medications Via GT/NGT" Policy and Procedure, revised 04/05, included the following: Policy: "To ensure that the residents with a GT/NGT are receiving all medications in accordance with manufacturer's and professional standards of practice." Procedure: "Inject approximately 30 cc of air into the GT/NGT with a 60 cc catheter tipped syringe, to check for placement by ascultation (a swish of air heard with a stethoscope, will indicate placement) Pull back on the plunger of the syringe to check for residual stomach contents (note the amount of residual gastric contents, physicians may order to hold medications or feedings with residual parameters)"	F 322		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION	F 323		3/9/09

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F 323	Continued From page 21 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, the facility failed to provide adequate supervision to prevent residents from eloping from the secured Alzheimer's unit for 3 of 30 residents (#27, #29, #30). Findings include: Resident #27 Resident #27 was admitted to the locked Alzheimer's unit of the facility on 12/16/08, with a diagnosis of dementia. The records indicated the resident was ambulatory and required redirection due to his dementia. On 12/22/08, Resident #27 tried to leave the facility through the alarmed exit door of the Alzheimer's unit, but was redirected. On 1/10/09, an incident report revealed the alarmed exit door in the locked Alzheimer's unit sounded off at 9:20 p.m. A head count was done and Resident #27 was missing. Resident #27 was found wandering across the street from the facility. Resident #29	F 323		

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Resident #29 was admitted to the facility's Alzheimer's unit on 12/22/08, with a diagnosis of Alzheimer's disease and dementia. The history and physical indicated that the resident was profoundly confused.

On 1/14/09, Resident #29 eloped from the secured Alzheimer's unit through the alarmed exit door and was later found wandering in the facility's parking lot.

The facility's current policy and procedures were not effective in preventing Resident #27 and Resident #29 from eloping from the secured Alzheimer's unit alarmed exit door.

Complaints #20730, #20626, #20630

Resident #30

Resident #30 was a 76 year old male admitted to the facility on 12/1/2006 with diagnoses including cerebral vascular accident, dementia with psychosis, and chronic obstructive pulmonary disease. He required extensive assistance in most of his ADLs (Activities of Daily Living), including transfer. He was wheelchair bound and propelled himself within the facility once up in the wheelchair.

On 12/30/08 at approximately 8:00 PM, the alarm at the ambulance entrance went off. The cleaning staff who was going to mop the lobby heard the alarm and notified the nursing supervisor. The supervisor immediately went to the doorway and the door was still open. She turned off the alarm, looked outside and did not see anyone.

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The nursing supervisor called all floors to do a resident search. All residents were accounted for except Resident #30.

During the time of the resident search, a CNA went to the front door to open the door for a family member who was returning another resident. The resident's family informed the CNA that a resident in a wheelchair was across the street. The CNA immediately ran across the street and found Resident #30. A passerby had stopped in the street, diverted traffic and waited with Resident #30 to prevent any injury.

The CNA brought Mr. Washington back to the facility and he was returned to his room. The facility immediately performed a body check, performed lab tests including U/A (Urinalysis), C&S (culture and sensitivity) and CBC (Complete Blood Count) to rule out infections. The facility notified the physician and the family. The facility updated the care plan, attached a wanderguard for the resident's safety and placed Resident #30 in the locked unit to prevent further elopements.

One statement from the nursing supervisor indicated that no one had heard the alarm go off. She added, "The alarm at the ambulance entrance is barely heard at the Nurses stations (200 & 300 Hall). We usually hear the alarm when it goes off. I don't know if the volume was adjusted down."

The 1/30/09 at 12:00 PM observation, the Administrator tested the alarm at the ambulance entrance. The alarm was very loud at the doorway. The receptionist, who was located in an office near the lobby, responded to the alarm.

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F 323	Continued From page 24 The Administrator indicated it was the receptionist's responsibility to respond. The Administrator added that the receptionist was in that location until around 8:00 PM. After that time, there was no one physically located near the lobby. The Administrator indicated that usually the staff in the 200 & 300 hallway would hear the alarm and respond. At 12:10 PM, three staff members in the 200 Hall were interviewed if they heard the alarm go off. No one heard the alarm. One staff member stated she was in the Dining Room, another at the nurses station and the third (maintenance) staff was in the hallway. The Unit Manager of the 200 Hall indicated the staff usually do not hear the alarm go off, especially if they are in a resident's room. At 12:15 PM, three staff members on the 300 Hall indicated they did not hear the alarm. At 2:30 PM, the Administrator was informed that no one had heard the alarm. The facility implemented the Missing Resident policy and the resident was located during the initial search of rooms. Therefore, the complete ground search was not initiated.	F 323		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;	F 328		3/9/09

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F 328	Continued From page 25 Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate care of suctioning equipment to decrease the risk of infection for 1 of 30 residents (#8). Findings include: Resident #8 Resident #8 was a 60 year old male admitted to the facility with diagnoses including cerebral vascular accident, hypertension, chronic dementia and depression. The resident had a Percutaneous Endoscopic Gastrostomy (PEG) tube and received tube feedings daily. He had oxygen in place via nasal cannula and was suctioned as necessary. The resident was alert, but was not verbally responsive and was totally dependent for care. On 1/28/09 at 4:15 PM, a portable suction machine was on the bedside dresser. The Yankauer suction catheter and suction canister were both labeled 1/10/09. The suction canister contained 250 cc (cubic centimeters) clear liquid with mucous. One end of the suction tubing was disconnected from the suction canister and was touching the floor.	F 328		

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F 328	Continued From page 26 Employee # 7 removed the suction catheter and indicated he did not know how often the suction equipment should be changed. He asked the unit manager to clarify the policy. On 1/29/09 at 9 AM, the unit manager indicated that the suction equipment should be changed daily according to the policy. Review of the facility policy titled, "Suctioning-Nasopharyngeal/Oropharyngeal;" effective 12/08 revealed: Procedure: Nursing Action " ...20. Discard suctioning catheter, glove, and basin each time."	F 328		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431		3/9/09

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F 431	Continued From page 27 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were dated when opened and labeled in accordance with currently accepted professional principles. Findings include: On 1/27/09 at 9:30 AM, there was a topical treatment treatment box on the counter in the 100 hall Medication Room. The treatment box contained three partially used tubes of multiple dose topical medication creams. There were no labels on any of the three tubes indicating the dates they were opened or which residents were to receive them. The medications included the following: - Mupirocin 2% topical ointment, 22 grams - Clotrimazole Betamethasone topical 1% cream, 45 grams - Triamcinolone Acetonide topical 1% cream, 80 grams	F 431		

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	295073	A. BUILDING _____ B. WING _____	01/30/2009

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F 431	Continued From page 28 On 1/27/09 at 9:30 AM, the DON confirmed that, according to facility policy, the three topical medications should have had a "date opened" sticker or the date opened written on the tube. The DON confirmed there was no date opened on any of the medications and no label indicating the date opened or the residents' name on any of the three topical medications. The DON could not identify which residents the topical medications were prescribed. The DON indicated the medication was considered expired and should be discarded once the physician's order expired. On 1/30/09 at 1:35 PM, the DON indicated the facility's medication policy required all nurses to attach a " Date Opened" sticker or write the date opened on all multiple dose medications that were to be administered to residents at the facility. The DON indicated all multiple dose medications used for residents at the facility were to be considered expired and discarded once the physician's order expired. The facility's "Medication Label and Expiration Policy," revised 04/05, indicated the drug labels were to include the resident's name. Medications dispensed in the manufacturer's original multiple dose containers that included creams and ointments would expire one year after opening. Multiple dose medication containers shall be dispensed with a date opened sticker attached. "The nurse opening the container of medication is responsible for writing in the date opened on the sticker." On 1/27/09 at 2:00 PM, observation of the medication Room on the 200 Hall revealed the following:	F 431		

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F 431	Continued From page 29 - Benadryl Dye Free Allergy Tabs - 9 capsules; Lot # 458871; Expiration Date 4/20/08 The unit manager confirmed the expiration date and disposed of the 9 capsules.	F 431		
F 465 SS=F	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, sanitary and comfortable environment for residents, staff and the public. Findings include: Issue One On 1/28/09 at 9:00 AM during the group meeting, several of the residents indicated the water was either too hot or too cold. One resident indicated this had been an on-going problem for weeks. During the initial tour on 1/27/09 at 9:00 AM, the water in the bathroom sink in Room 101 was cold. The Nurse Manager of the 100 hall confirmed the water was cold. The Director of Maintenance indicated the facility was having some trouble with one of the water heaters. He indicated he was going to turn the temperature up. At 9:00 AM, the temperature in Room 101	F 465		3/9/09

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measured at 86 degrees Fahrenheit. The water temperature in Room 106 measured at 80 degrees Fahrenheit and in Room 110 the water temperature measured at 108 degrees Fahrenheit.

On 1/27/09 beginning at 4:05 PM, the water temperatures in sample resident bathroom sinks were checked and included the following:

- Room 317 = 118.4 degrees Fahrenheit,
- Room 323 = 119 degrees Fahrenheit,
- Room 302 = 120 degrees Fahrenheit,
- Room 303 = 118 degrees Fahrenheit, and
- Room 215 = 130.2 degrees Fahrenheit.

On 01/27/09 at 4:05 PM, the water temperatures in random resident bathroom sinks were checked and included the following:

- Room 105 = 122 degrees Fahrenheit
- Room 122 = 122 degrees Fahrenheit
- Room 124 = 130 degrees Fahrenheit
- Room 125 = 124 degrees Fahrenheit

On 1/27/09 at 4:45 PM, the Director of Maintenance was informed of the elevated water temperatures. The Director of Maintenance stated the boiler had been "tweaked" and water temperatures would be checked "in an hour or so."

On 1/27/09 at 4:45 PM, the Administrator and Director of Nursing (DON) were informed of the elevated hot water temperatures in the resident bathroom sinks. The Director of Nursing informed "all staff" by written notice and in-service of the elevated hot water temperatures; all staff were

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instructed "no showers or bed baths to be given until further notice".

On 1/27/09 beginning at 5:10 PM, the water temperatures in resident bathroom sinks were re-checked and included the following:

- Room 317 = 118.4 degrees Fahrenheit,
- Room 323 = 119.4 degrees Fahrenheit,
- Room 302 = 120.1 degrees Fahrenheit,
- Room 303 = 116 degrees Fahrenheit, and
- Room 215 = 124.5 degrees Fahrenheit.

On 01/27/09 at 5:15 PM, the water temperatures were re-checked in resident bathroom sinks and included the following:

- Room 105 = 120 degrees Fahrenheit
- Room 122 = 120 degrees Fahrenheit
- Room 124 = 122 degrees Fahrenheit
- Room 125 = 120 degrees Fahrenheit

On 1/27/09 at 5:40 PM, the Administrator, DON, and Director of Maintenance were informed of the persistent elevated hot water temperatures in resident bathrooms. The Director of Maintenance reported he called the commercial plumber for the building and the plumber was scheduled for a facility visit on 1/28/09 at 11:00 AM.

On 01/27/09 at 5:55 PM, the water temperatures were re-checked in the same resident bathroom sinks and included the following:

- Room 105 = 119 degrees Fahrenheit
- Room 122 = 120 degrees Fahrenheit
- Room 124 = 125 degrees Fahrenheit
- Room 125 = 123 degrees Fahrenheit

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On 1/27/09 at 6:15 PM, the Administrator, DON, two additional maintenance employees, and the Director of Maintenance (via speaker phone) discussed the persistent elevated hot water temperatures. The hot water temperatures in the resident bathroom sinks were greater than 110 degrees Fahrenheit and did not drop in temperature as expected. The decision was made to turn off all hot water in the resident bathrooms and shower rooms.

On 1/27/09 at 8:34 PM, the hot water was turned off in all resident bathroom sinks and shower rooms.

Note: The hot water systems for the kitchen and laundry room were separate from the hot water system for the resident bathrooms. The kitchen and laundry room hot water systems remained intact throughout the survey.

On 1/28/09, the hot water remained off in all resident bathroom sinks and shower rooms. The plumbing replacement parts were not available for installation until mid-afternoon.

On 1/28/09 in the late afternoon, a hot water temperature check in random resident bathroom sinks revealed inconsistent hot water temperatures. The Director of Nursing informed "all staff" by written notice and in-service of the inconsistent hot water temperatures. The staff were directed, "No showers or bed baths to be given until further notice."

On 1/28/09 at 5:24 PM, the Administrator and Director of Maintenance made the decision to turn off all hot water in the resident bathroom sinks and shower rooms. The hot water remained

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turned off until additional plumbing parts were installed on 1/29/09 in the morning.

On 1/29/09 in the mid-afternoon, hot water temperatures in resident bathrooms and shower rooms were measured between 95 - 110 degrees Fahrenheit.

Issue Two

On 1/29/09 at 3:00 PM, a tour of the facility revealed the following environmental issues:

- The non-slip surface on the parallel bars in the 100 hall physical therapy room was peeled up and represented a trip hazard for residents.

- The rug in the front lobby had dark brown and black stains; the rug curled up when objects were wheeled over it causing a potential trip hazard.

- The dry wall next to the 200 hall dining room sink area had water damage. The dry wall around the sink was bubbled and peeled away from the wall. The faucet was covered with brown and white corrosion-like material.

- The bases of all showers in the 200 hall shower room were missing caulking.

- The floor in front of Room 318 on the 300 hall was buckled and the tile around a drain cover was cracked and uneven, making it a potential trip hazard.

- The 300 hall women's shower room had a brownish/black substance around the base of all four showers and there was water damage to the dry wall by one of the showers. The dry wall by

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F 465	Continued From page 34 the shower was bubbled and peeling away from the wall.	F 465		